



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TENNESSEE 37243
TENNESSEE BOARD OF PHYSICAL THERAPY
(615) 741-3807 or 1-800-778-4123
www.tn.gov/health

**APPLICATION INSTRUCTIONS FOR LICENSURE AS A PHYSICAL THERAPIST
AND
PHYSICAL THERAPIST ASSISTANT
LICENSURE APPLICATION CHECK SHEET**

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice physical therapy.

NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.

1. Complete pages 4 thru 9; only page 9 is to be signed, dated and notarized.	
2. Tape (not staple) a recent 2x2 only full-faced, passport type photograph to the first page of the application. Computer generated images are not acceptable	
3. Determine the correct amount of fees to be paid according to the fee schedule (pages 12 and 13). Attach check or money order for the proper amount, made payable to the State of Tennessee .	
4. All applicants must submit an original letter of recommendation (signed and dated), attesting to their good moral character. This letter must be from a Physical Therapist or Physical Therapist Assistant licensed in the U.S. (This letter cannot be from a relative).	
5. You must have your scores reported by the FSBPT Score Transfer Service if you have previously passed the National Physical Therapy Examination by Tennessee standards. Exams taken prior to July 12, 1995, will be based on the norm referenced scoring method. All exams taken July 12, 1995 and after, will be based on the criterion referenced scoring method. Please visit www.fsbpt.org to order the score transfer, or call 703-299-3100.	

6. You must request your school to send official transcripts that show degree and date conferred before permanent licensure can be granted. Transcripts must come directly from the school to the Board's Administrative Office. Please complete the "Education Verification" form (Attachment 1, page 10) to have the school send official transcripts. If you are not sure if your school's PT/PTA program is CAPTE, contact the school or the American Physical Therapy Association (APTA) for this information. You may want to contact your school to see if there is a fee for this process. If you have completed all the requirements for your degree and your diploma or transcripts are not available, you can have the Program Director of the school send a letter of verification that all requirements for your degree have been completed. This will enable you to be deemed eligible for the exam.	
7. If you hold or have a certificate/license/permit to practice any profession, complete the "Verification from Other State Certification Boards" form (Attachment 2, page 11) and send to each state. Each state must submit the verification of certification, licensure or permit directly to Tennessee. You may want to contact the other licensing board(s) to see if there is a fee for this purpose.	
8. Documentation submitted to the Board by International graduates that is not written in English, must have an English translation. The English translation of the documents must be certified.	
<p>9. International Graduates (even if you are licensed in another state in the U.S.) must have a "Comprehensive Credential Evaluation Certificate for the TN Physical Therapist" from the foreign Credentialing Commission on Physical Therapy (FCCPT) or a comparable evaluation and documentation from the International Consultants of Delaware (ICD), submitted directly to the Board from the FCCPT (a Type 1 Certificate) or ICD (comparable to the Type 1 Certificate from the FCCPT), before applying for licensure in TN as a Physical Therapist or Physical Therapist Assistant.</p> <p style="padding-left: 40px;">FCCPT 124 West Street South, Third Floor Alexandria, VA 22314 (703) 684-8406 www.fccpt.org</p> <p style="padding-left: 40px;">ICD P.O. Box 8629 Philadelphia, PA 19101-8629 (215) 222-8454 ext 603 www.icdeval.com</p> <p>Please note that all International Educated applicants will be required to complete a 480 hour Supervised Clinical Practice (in TN) after educational credentials have been approved by the Board.</p>	
10. All exam applicants can register to take the exam at www.fsbpt.org . International Educated applicants should not register for the exam until after the Board's approval of educational credentials.	
11. If you are applying for a license as a Physical Therapist you must complete and return the "Mandatory Practitioner Profile" with your application before a license can be granted. For instructions, click here .	
12. If you wish to obtain certification to perform EMG's please refer to Rule 1150-1-.04(4) for requirements.	
13. Criminal Background Check. To obtain instructions for a criminal background check, click here .	
14. All applicants must complete the Declaration of Citizenship attachment	

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. All application fees are **non-refundable**.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Board of Physical Therapy
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

For Federal Express or Special Courier:
Board of Physical Therapy
665 Mainstream Drive, 2nd Floor
Nashville, TN 37228

3. **Allow fourteen (14) working days for information mailed to our office to be received and placed in your file.** Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
4. **We will discuss application status with the applicant, applicant's spouse or to whomever may hold power of attorney only.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from the applicant only. Status information will be mailed to the address listed on the application.
5. An initial deficiency letter will be sent to you by certified mail to notify you of documentation not received to complete your application process by the Board office.
6. **Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**
7. If you are taking an exam in Tennessee the average time for receipt of scores from the FSBPT is three to four days. An additional week (1) is required by our office for processing. Exam information (i.e. scores, pass, fail) **will not** be given over the phone.
8. It is recommended that you **do not** make arrangements to accept employment as a Physical Therapy or a Physical Therapist Assistant Practitioner in Tennessee until you are granted a license by the Tennessee Board of Physical Therapy.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee License from the Board in your possession before you may lawfully practice as either a Physical Therapist or Physical Therapist Assistant.

ATTACH A
CURRENT
FULL-FACE 2X2
PHOTOGRAPH



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TENNESSEE 37243
**BOARD OF PHYSICAL THERAPY
LICENSURE APPLICATION
800-778-4123 or 615-741-3807**

Choose the appropriate licensure category and method for which you are applying. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

LICENSURE ALTERNATIVES

A. _____ Physical Therapist License	B. _____ Physical Therapist Assistant License
_____ Reciprocity from another state	_____ Reciprocity from another state
_____ Examination	_____ Examination

PERSONAL INFORMATION

Name: _____
Last First Middle/Maiden

Social Security Number: _____ - _____ - _____ Date of Birth: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §.36-5-1301 (a), as authorized by 42 U.S.C. §405 (c) (2) (C) (i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

U.S. Citizen: ☐ YES ☐ NO All applicants **must** complete the Declaration of Citizenship attachment.

Do you wish to receive notification, including renewal notification, from the Department of Health via email?

☐ YES ☐ NO Email Address: _____

Place of Birth: _____ County (TN Applicants Only): _____

Mailing Address: _____ Practice Address: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

(Optional - for statistical purposes only) Sex: ☐ Male ☐ Female Race: _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high or middle school. Use the back of [this page](#) if you need additional space.

From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution (Physical Therapy)	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded

Please complete your entire employment history (relating to physical therapy) starting with the most current position first. Use the back of [this page](#) if you need additional space. **(The Board does not accept resumes.)**

DATES

LOCATION

POSITION AND DUTIES

From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)
From: _____	To: _____	
Mo/Yr	Mo/Yr	(City/State)

LICENSURE INFORMATION

List below **ALL STATES, COUNTIES OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED PERMITTED OR CERTIFIED** as a Physical Therapy Practitioner. Additional pages may be added if necessary. Submit a copy of **Attachment #2** to all such States, counties, or provinces regarding such licensure, certification or permit. Use the back of [this page](#) if you need additional space. **(If none mark N/A)**

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, counties or provinces in which you hold or have ever held a license, certification or permit as a health professional other than a Physical Therapy Practitioner. Submit a copy of **Attachment #2** to all such states, counties or provinces regarding such licensure, certification or permit. Use the back of [this page](#) if you need additional space. **(If none mark N/A)**

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

	Yes	No
1. Have you ever applied for a Physical Therapy license in Tennessee? Check one: () Assistant () Therapist	_____	_____
2. Have you ever taken the PES or ASI National Physical Therapy Examination (NPTE) Check one () Assistant () Therapist		
If yes, please give dates on which the exam was taken _____	_____	_____
3. Are you currently scheduled to take the PES NPTE in any other state?		
If yes, please list state in which you are scheduled to take the NPTE _____	_____	_____
4. Have you ever failed the NPTE? If yes, how many times _____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, **attach an explanation on a separate sheet.** *In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.*

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis (if necessary) and exercise reasoned judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedics, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES

NO

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field or practice, the setting or the manner in which you have chosen to practice?

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?	_____	_____
a. If yes, have your doctor submit a letter to state if they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice Physical Therapy in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or restriction or disciplinary action?	_____	_____
7. Have you ever failed a Physical Therapy licensure examination?	_____	_____
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
9. Have you ever been rejected or censured by a professional society?	_____	_____
10. In relation to the performance of your professional services in any profession:	_____	_____
a. Have you ever had a final judgment rendered against you; or	_____	_____
b. Have you ever had settlement of any legal action rendered against you; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and identified as
(Applicant's Name) (City) (State)
the person referred to in this application, attests to the truth of each statement made in said application. **I further swear that I have read and understand the law and the rules and regulations which are available on the website under statutes, rules and policies and agree to abide by the them in the practice of Physical Therapy in the State of Tennessee.**

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a Board interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Physical Therapy.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

In order to comply with federal statutes, the Board of Physical Therapy is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this ____ day of _____, 20____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

Attachment 1



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243

BOARD OF PHYSICAL THERAPY
(615) 741-3807 or 1-800-778-4123

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your physical therapy educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a certificate or permit to practice physical therapy in the State of Tennessee. The Board of Physical Therapy requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Board of Physical Therapy
665 Mainstream Dr., 2nd Floor
Nashville, TN 37243

Thank you for your cooperation and prompt response.

Applicant's Signature _____

Date _____

Attachment 2



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TENNESSEE 37243
BOARD OF PHYSICAL THERAPY
(615) 741-3807 or 1-800-778-4123

VERIFICATION FROM OTHER STATE CERTIFICATION BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the certification board in EACH state where you **hold or have ever held** a certificate/license/permit to practice any profession. (Copies of this form can be used.) **Note:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license/certificate/permit to practice _____
(Profession)

with **(check one)** ☐ License ☐ Certificate ☐ Permit

Number _____ on _____, in the State of _____.
(Date)

The Tennessee Board of Physical Therapy requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Physical Therapy.

Applicant's printed name: _____

Applicant's signature: _____ Date: _____

To Be Completed By Administrative Office of State Certification Board

Name In Full As It Appears On License/Certificate or Permit:

(First)

(M.I.)

(Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Date of Expiration: _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)

_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? _____ Yes _____ No

Is there any derogatory information on file? _____ Yes _____ No
If yes, Please attach supporting documentation.

Authorized Signature

Title

Date

FEE SCHEDULE FOR THE BOARD OF PHYSICAL THERAPY

CIRCLE AND PAY ONLY **ONE** METHOD OF APPLICATION

PHYSICAL THERAPIST

PT By examination: (Total fee due \$ 135.00)		
\$ 100.00	APPLICATION FEE	09-001
\$ 25.00	LICENSE FEE	09-001
\$ 10.00	STATE REGULATORY FEE	09-006

PT By Reciprocity: (Total fee due \$ 235.00)		
\$ 100.00	APPLICATION FEE	09-001
\$ 100.00	RECIPROCITY FEE	09-001
\$ 25.00	LICENSE FEE	09-001
\$ 10.00	STATE REGULATORY FEE	09-006

NAME OF APPLICANT: _____
(PLEASE PRINT)

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE** TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION IF APPLYING AS A **PHYSICAL THERAPIST**.

FEE SCHEDULE FOR THE BOARD OF PHYSICAL THERAPY

CIRCLE AND PAY ONLY **ONE** METHOD OF APPLICATION

PHYSICAL THERAPY ASSISTANT

PTA By examination: (Total fee due \$ 125.00)		
\$ 90.00	APPLICATION FEE	25-001
\$ 25.00	LICENSE FEE	25-001
\$ 10.00	STATE REGULATORY FEE	25-006

PTA By Reciprocity: (Total fee due \$225.00)		
\$ 90.00	APPLICATION FEE	25-001
\$100.00	RECIPROCITY FEE	25-001
\$ 25.00	LICENSE FEE	25-001
\$ 10.00	STATE REGULATORY FEE	25-006

NAME OF APPLICANT: _____
(PLEASE PRINT)

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE** TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION IF APPLYING AS A **PHYSICAL THERAPY ASSISTANT**.

Fee Schedule



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DR.
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States ____Yes ____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status-- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.